**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

JAVIER SANCHEZ MD
3000 NORTH IH-35 SUITE 700
AUSTIN TX 78705

**Respondent Name**
EMPLOYERS INSURANCE CO OF WAUSAU

**Carrier's Austin Representative Box**
Box Number 01

**MFDR Tracking Number**
M4-12-0421-01

**MFDR Date Received**
OCTOBER 6, 2011

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Authorization request was submitted timely."

**Amount in Dispute:** $5465.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** The respondent did not submit a response to this request for medical fee dispute resolution.

**Response Submitted by:** None

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| October 18, 2010 | CPT Code 99243 - Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies | $260.00 | $0.00 |
| | CPT Code 33240 - Insertion of pacing cardioverter-defibrillator pulse generator only; with existing single lead | $735.18 | $0.00 |
| | CPT Code 33241 - Removal of pacing cardioverter-defibrillator pulse generator only | $1080.00 | $0.00 |
| | CPT Code 93612-26 - Intraventricular pacing | $650.00 | $0.00 |
| | CPT Code 93610-26 - Intra-atrial pacing | $500.00 | $0.00 |
| | CPT Code 93603-26 - Right ventricular recording | $785.00 | $0.00 |
| | CPT Code 93602-26 - Intra-atrial recording | $420.00 | $0.00 |

| | | | |
|---|---|---|---|
| TOTAL | | $5465.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 30, 2010
   - 196-Precertification/Authorization exceeded.
   - 663-Reimbursement has been calculated according to the state fee schedule guidelines.
   - 851-001-Payment denied/reduced for exceeded precertification/authorization. UMD recommends $0.00.
   - 900-100-Texas Rule 134.202(5)(B) requires the use of CMS billing, coding and reporting payment policies in effect on the DOS. Effective 01/01/10, consult codes are no longer reimbursable. Providers should bill the appropriate level E/M code for the service.
   - W1-Workers compensation state fee schedule adjustment.

**Issues**

1. Was the dispute filed in the form and manner required by 28 Texas Administrative Code §133.307?
2. Did the requestor support position that preauthorization was obtained for CPT codes 33240, 33241, 93612-26, 93610-26, 93603-26, and 93602-26?
3. Did the requestor's billing of CPT code 99243 in compliance with 28 Texas Administrative Code §134.203?
4. Is the requestor entitled to reimbursement?

**Findings**

1. 28 Texas Administrative Code §133.307(c)(2)(A), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a copy of all medical bill(s) . . . as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration"… Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the carrier and/or as submitted for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(A).

   28 Texas Administrative Code §133.307(c)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not include a copy of the EOB detailing the insurance carrier's response to the request for reconsideration. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(B).

   28 Texas Administrative Code §133.307(c)(2)(E), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).

   The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307.

2. The insurance carrier denied reimbursement for the disputed outpatient surgical services based upon reason codes "196-Precertification/Authorization exceeded," and "851-001-Payment denied/reduced for exceeded precertification/authorization. UMD recommends $0.00."

28 Texas Administrative Code §134.600 (c)(1)(B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:

(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

28 Texas Administrative Code §134.600(p)(2) states "Non-emergency health care requiring preauthorization includes: (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

The requestor did not submit documentation to support that the disputed services were preauthorized; therefore, reimbursement is not recommended.

3. The insurance carrier denied reimbursement for the disputed consultation, coded 99243, based upon reason codes "663-Reimbursement has been calculated according to the state fee schedule guidelines," and "900-100-Texas Rule 134.202(5)(B) requires the use of CMS billing, coding and reporting payment policies in effect on the DOS. Effective 01/01/10, consult codes are no longer reimbursable. Providers should bill the appropriate level E/M code for the service."

   Per 28 Texas Administrative Code §134.203(a)(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Per 28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   According to Medicare policy, effective January 1, 2010, the consultation codes are no longer recognized for Medicare part B payment . Therefore, reimbursement is not recommended for CPT codes 99243.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 6/21/2012<br>Date |
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## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box

17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.